control analysis corporation

PROGRAM REVIEW GUIDE FOR

THE ASSESSMENT OF STATE CONTROLS ON

ERRONEOUS MEDICAID EXPENDITURES

July 30, 1976

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1.0 INTRODUCTION

This review methodology is designed as a procedural guide to be used in carrying out state assessments of Medicaid claims processing control systems. The task of assessment is to evaluate the effectiveness of control procedures for detecting erroneous payments. For the purposes of these state assessments, erroneous payments are defined as any payments which are made contrary to clear-cut regulations or policy, Federal or State. As such, this definition excludes payments for services which may be considered overutilization where the latter is defined in terms of medical judgment, even while such payments may be contrary to policy in a general sense. While this area is viewed as being of great importance, it is excluded from the scope of the assessment. However, where certain utilization controls, such as prior authorization, have been established in the regulations, payments contrary to those controls are indeed defined as erroneous payments - e.g. payment for a claim lacking prior authorization where prior authorization is required. Thus, this guide deals with methods for enforcing policies rather than the setting of those policies themselves.

The review methodology is divided into three parts, described in Sections 3, 4, and 5. The first phase of the assessment is a qualitative investigation of the state's processing system and existing control procedures. The central task in this phase is to catalogue all possible erroneous payment situations as determined by Federal and State regulations and to ascertain the method of control for each of these situations. In this way, exemplary practices will be discovered and gaps in the existing control system observed. The second phase of the assessments consists of tabulating performance statistics, such as claim dollars reduced, disallowed, etc., for the various types of erroneous payments which a state controls. Such an analysis will help to point out the key areas in which controls have the greatest impact as well as give an indication of

undetected erroneous payments in some states which may not have a given control. Finally, the third phase of the assessment consists of a sample of paid claims and of claim refunds or adjustments, for the purposes of observing the prevalence of erroneous payments which are not detected by the state's control system.

The review methodology discussed above is designed to be performed by two people during a two-week visit to a state. Additionally, it can be expected that one person-week of advance preparation is necessary (described in Section 2) and that report-writing will require three person-weeks. This level of effort will be suitable for a team which has become proficient in conducting the review and is assessing a state which has a single fiscal agent or a single location for the processing of claims. The level of effort should be increased accordingly if a team is conducting its first assessment, of if there is more than one processing location, since it would be necessary to repeat many of the tasks. Section 6 gives suggestions for the management and time-phasing of the assessment.

2.0 PREPARATION FOR THE ASSESSMENT

Because of the short time in which the assessment is to be performed (two weeks), it is especially important that thorough preparations be made prior to the start of the assessment. Such preparations are of two types: general preparations to acquaint the reviewer with the issues and methods of the review process; and specific preparations related to the particular state to be assessed.

2.1 General Preparations

It is assumed that the reviewer is generally knowledgeable about the Medicaid program as well as claims processing methods and procedures. Additionally, the reviewer should become acquainted with various types of assessments, the methods used, and the issues addressed in those assessments. Toward this end, the following reading material will be helpful:

Assessment Guides

1. Financial Review Guide for Selected Public Assistance and Rehabilitation Programs Under the Social Security Act, Office of Management, Division of State Grants Administration, Social and Rehabilitation Services.
2. Audit Guides for the review of selected aspects of the Medical Assistance Program, HEW Audit Agency.
3. State Medicaid Assessment Guide, Medical Services Administration.

Examples of Assessments or Audits

1. Assessments of controls on erroneous Medicaid expenditures in eight states, performed by Control Analysis Corporation under contract #SRS-500-75-0008.
2. Audits of state Medicaid programs by the HEW Audit Agency.
3. Audits of state Medicaid programs by the General Accounting Office.
4. State assessments performed by the Program Monitoring Division of the Medical Services Administration.
5. Assessments performed by the Office of States Grants Administration using the Financial Review Guides.
6. Internal audits performed by states of their own Medicaid programs, e.g.:
   a) Audit of Medi-Cal Management System by the California Auditor General, April 2, 1973.
   b) A Review of the Medi-Cal Program, prepared by the Audits Division, Department of Finance, State of California, December, 1974.

Finally, it is assumed that the reviewer is familiar with the report, "A Guide for the Control of Erroneous Medicaid Expenditures", July 1976, prepared by Control Analysis Corporation under contract #SRS-500-75-0008. This report, in discussing desirable control practices, is a useful companion to this review guide, in that it provides the reviewer with a frame of reference for many of the questions to be asked in the state assessment.

2.2 Specific Preparations

The purpose of the specific preparations for the state assessment is to accomplish the following tasks:

1. Become familiar with the specific policy and regulations of the state to be assessed,
2. Develop a list of potential erroneous payment situations applicable to the state,
3. Become generally familiar with the state organization and, specifically, the delegation of responsibilities for claims processing and other controls for erroneous payments,
4. Review documentation of the manual and computer procedures for the claims processing system, and
5. Schedule meetings with the appropriate personnel as required to implement the review methodology.

Ideally, these preparations should be made in the course of an on-site visit to the state several weeks in advance of the assessment. If this is done, such an advance visit can also serve to identify any specific data which should be saved or specially collected in the weeks prior to the assessment. However, if such an advance visit is not possible, the specific preparations can be accomplished in a visit just prior to the assessment or alternatively in telephone conversations to request the needed documentation and make the necessary arrangements.

2.2.1 Step 1: Gather and Review Documentation

The following documentation should be requested and reviewed:

1. State Plan for Medical Assistance
2. Provider manuals and/or billing instructions; most recent complete set, including any memos or other correspondence incorporating revisions in regulations or billing instructions
3. Organization charts

   Medical Assistance Unit

   Unit responsible for claims processing

   Unit responsible for data processing

   Departments or agencies to which the above organization units are responsible

   Fiscal agent, if any
4. Information packet for new recipient
5. Documentation describing claims processing system (manual and computerized segments), including procedural manuals or training documents
6. Claim forms
7. Forms used commonly in the claims processing system
8. Sample of remittance advice
9. Samples of denial or reject letters
10. List of remittance messages or codes explaining claim disposition to providers
11. RVS (Relative Value Studies) or other manual giving procedure terminology and conventions for physician bills
12. List of reports (manual or computer-prepared) associated

with the claims processing system, including detail listings as well as statistical or management reports

13. Copy of contract with fiscal agent, if any, and RFP
14. Copies of previous audits by HEW Audit Agency, GAO, the state, etc.

2.2.2 Step 2: Identify Potential Erroneous Payment Claim Situations

Erroneous payments are defined as payments that are made which are contrary to clear-cut regulations and policy, either State or Federal. The purpose of this step is to identify the various types of erroneous payment situations which could occur in the given state if controls were lacking. This may be accomplished by reviewing the State Plan and the instructions to providers (obtained in Step 1) as well as making use of information on erroneous payments in other states.

Appendix A provides a basic list of potential erroneous payment situations which are generally applicable to all states. These situations may be considered as a "test matrix" which can be used to determine the adequacy of state controls. That is, if the state had a facility for testing system response to fictitious claims, the list of claim situations in Appendix A could be used to generate a comprehensive set of test claims which are known to be erroneous and which thus provide a good test of the state's controls. While the submittal of fictitious test claims is beyond the scope of a two-week state assessment, such a list of erroneous situations will alternatively be used as an interview guide to determine the presence or absence of controls for detecting each such situation. That is, one can ask, "what would occur if such a claim were submitted." The list of erroneous claim situations has been developed for the purpose of such an approach, as discussed in subsequent sections of this guide.

For convenience purposes, the erroneous claim situations in Appendix A have been organized into the following categories:

a) Ineligible Recipient

b) Ineligible Provider

c) Duplicate Claim (exact or near)

d) Above Allowed "Reasonable" Charge

e) Other Sources of Payment Available (Other Insurance, Accident Liability, Patient Spenddown, Medicare, or Copayment)

f) Incorrect and/or Incomplete Claim

g) Other Payments not Allowed

During the preparations for the state assessment, the list in Appendix A must be custom-tailored to the specific policy and regulations of the state. In some cases, the list indicates that particular erroneous claim situations are conditional on state regulations, and in these cases, the State Plan and provider instructions must be examined to determine whether the claim situation must be changed to fit the particular state situation. Additionally, the State Plan and provider instructions must be examined to determine whether additional claim situations must be added to reflect specific state policy or regulations. For example, if the provider instructions state that "chiropractic visits over two per month must be prior authorized," then an appropriate erroneous claim situation is "Claim for third or greater chiropractic visit in a month, without prior authorization."

2.2.3 Step 3: Schedule Meetings with Appropriate Personnel .

In advance of the state assessment, it is necessary to schedule the following meetings for the start of the assessment:

1. Meetings with claims processing managers to discuss an overview of claims processing controls and to provide a "walk-through" of the claims processing operations, from receipt of the invoice in the mailroom through payment or rejection of the claim. The anticipated time of this meeting is one-half day.

2. Meetings with systems analysts and claim processing supervisors to discuss erroneous payment claim situations. (See Section 3 for more discussion on this phase of the assessment.) It is anticipated that such meetings will occur over a three to five day period, with perhaps one to two days spent with a computer systems analyst familiar with the claims processing edits, and about one day with the claims processing supervisor for each major claim type. It should be noted that a flexible schedule should be designed for such meetings, as it will often become apparent that additional personnel must be brought into the discussions and that the time spent with specific personnel will depend upon the details of their familiarity with the system controls

3.0 QUALITATIVE ANALYSIS

The purpose of this phase of the state assessment is to provide a thorough qualitative evaluation of the state's control procedures for erroneous payments. During the pre-assessment preparations (See Section 2), state regulations will have been reviewed to catalogue claim situations which could potentially result in erroneous payments. The ability of the state's claims processing system to detect these claim situations will now be studied to determine detection gaps and potential failures in the edits and audits employed. Additionally, other sources of erroneous payments which may not be directly associated with claims processing (for example, cost settlement audits, file maintenance procedures, etc.) will be investigated through a series of interviews.

3.1 Step 1: Perform Functional Analysis of Claims Processing Controls

The purpose of this step is to determine, for each claim situation specified in Appendix A and for any additional situations identified as applicable to the state, the controls utilized in the state's claims processing system to prevent an erroneous payment. For each claim situation listed, the results of the investigation should be noted on the worksheet shown in Appendix A: disposition of claim by the normal operating procedures (e.g. claim denied, returned to provider, payment reduced, etc.), method of detection of the situation (e.g. manual vs. computer identification), potential and actual use of edit over-rides (e.g. is this edit active at all times, for all providers, etc.), and any other comments which are applicable. The information summarized on these worksheets will provide the basis for a qualitative evaluation of the edits and audits employed by the claims processing operations.

Note that for many erroneous claim situations in Appendix A, annotations are given in the right-hand margin. These annotations are designed to aid the interviewer in understanding the claim situation and in ascertaining the appropriate answers.

Information on the capabilities of normal edits and audits to detect the various erroneous claim situations should be based on interviews with persons familiar with the operating system and on reviews of the system documentation. The personnel interviewed should be sufficiently familiar with the system to answer specifically how each situation is controlled. In some cases, verification that these edits and audits are actually in operation may be made by observation and by reviewing the listings of rejected, suspended, denied claims, etc. For each erroneous payment category, types of erroneous claims which could possibly be paid without detection should be noted.

The interviewer must ask questions in sufficient detail to satisy himself that an area is properly controlled. When told that an area is controlled, the interviewer must ascertain exactly how the control is accomplished. Also, the interviewer must be certain that the personnel interviewed clearly understand that the questions are aimed not at determining what policies the state has adopted, but rather what controls are actually in operation to enforce those policies. For example, a state may have a policy to disallow certain types of claims but no control which serves to detect those claims. When asked the disposition of such a situation, the personnel interviewed may state that such claims are not allowed, but such a response reflects policy rather than the realities of the claims processing controls. Thus, considerable caution must be exercised to insure that the responses received are in fact the appropriate responses for the purposes of assessing the control mechanisms present.

The primary purpose of this functional analysis is to detect gaps and potential shortcomings of the edits and audits regularly employed. No attempt to estimate the dollar value of undetected claims is made with this analysis. Some indication of the significance of control gaps will be apparent in subsequent phases of the analysis, namely, the samples of paid claims and of claim adjustments (See Section 5).

It should be noted that procedures apart from routine claims processing also impact on erroneous payments, and these will be reviewed in Step 2. Results from these reviews should be incorporated into the functional analysis whenever operating procedures, or lack of procedures could potentially result in erroneous payments. The resulting functional analysis will provide a thorough qualitative evaluation of the state's control procedures and will provide direction for the more quantitative analyses discussed in Sections 4 and 5.

3.2 Step 2: Conduct Additional Interviews

There are several areas of a state's operations which affect the ability to prevent erroneous payments, but which are distinct from the routine claims processing operations. The purpose of Step 2 is to examine these areas through a series of interviews.

The areas in which interviews will be administered are as follows:

1. System Orientation
2. Bypass and Override Procedures
3. Financial System
4. Controls on Cost-Reimbursed Providers
5. Post-Payment Edits
6. Information Feedback
7. Claim Format
8. Personnel and Training
9. File Maintenance
10. Quality Assurance Procedures
11. System Evaluation and Planning

Individual questionnaire worksheets for these topics are given in Appendix B.

4.0 MEASUREMENT OF CONTROL SYSTEM PERFORMANCE

The purpose of this phase of the state assessment is to tabulate performance statistics such as claim dollars reduced, disallowed, or returned, for the various types of erroneous payments which a state controls. Such an analysis will be useful in two ways. First, it will highlight those areas in which the state's controls appear to have the greatest impact, by providing quantitative data on control performance. Second, the process of performing such an analysis will serve as a vehicle for the reviewer to gain an intimate first-hand knowledge of the workings of the control system. The insights and observations concerning the system operations which are gained in this phase of the assessment will complement the information gathered during the qualitative analysis of the first phase.

In what follows, we outline the various steps needed to produce the desired tabulations, and we present a suggested format for the tabulations. The approach makes use of carefully selected samples in addition to existing state performance statistics. It should be noted that, in some states, it will not be possible to complete all steps of this analysis within the time constraints of the assessment, due to the inaccessibility of needed data. In such cases, the approach can nevertheless be applied in part. The steps below have been listed in increasing levels of difficulty as well as increasing levels of useful output. If it is not possible to complete all of the steps, a partial analysis will nevertheless be useful in providing some quantitative data as well as exposing the reviewer to the actual system operations.

Prior to commencing with this phase of the assessment, it is essential that the reviewer have a good basic understanding of the claims processing system and the methods for controlling the most significant classes of erroneous payments. The reviewer should be familiar with all of the possible claim statuses and

dispositions, where and by whom they are assigned, and how they apply to the major classes of erroneous payments. The reviewer should also be familiar with the mechanisms used for assigning such claim statuses: the forms used, the paper flow, the messages sent to providers, etc.

4.1 Step 1: Obtain Existing State Performance Statistics

In this step, the reviewer should obtain, on a weekly, monthly, quarterly, or annual basis, any existing state statistics which report claims paid and claims reduced, disallowed, or returned to providers, with as much detail as is available on the reasons for such "cutbacks".[1] The availability of such data will differ greatly from state to state, with some states collecting only broad overall statistics and others routinely collecting statistics for many different types of reductions or denials. Care must be taken to obtain correct interpretation of all of the reported statistics. Besides insuring success of the subsequent efforts to refine the statistics, this will aid in the understanding of the system processing and the methods of accounting for erroneous payments.

4.2 Step 2: Determine Possible Measurement Points for System Controls

In this step, the reviewer should determine the various points in the system where there is evidence of claims which are reduced, corrected, disallowed, or returned to providers. Examples of possible measurement points include:

1. Computer listings of reduced, disallowed, or returned claims printed for control purposes or as part of the remittances sent to providers.

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[1] Note, the state's third party recoveries should be included in the statistics gathered, if available.

2. Claim correction documents or listings about to be entered into the computer.
3. Form reject letters about to be mailed to providers.
4. Claim documents which have been altered by claims examiners.
5. Claims which have been adjudicated by higher-level examiners or consultants.

The basic task is to pinpoint the time and location where claim dispositions are assigned or where there is evidence of such assignment. It is important that the measurement points identified encompass all of the ways in which claim payments are impacted by the control system. As a checklist for insuring that this is so, the reviewer should determine that the measurement points would detect the operation of controls for each of the major erroneous payment situations listed at the beginning of Appendix A.

4.3 Step 3: Select Measurement Points to be Sampled

For each type of erroneous payment which the state controls, there may be more than one possible point identified above where system performance may be observed and measured. The purpose of this step is to select those measurement points where samples are to be taken to measure the extent of control activity. Before doing so, the reviewer should observe the processing at several of the measurement points to gain a clear understanding of the process, and should select small samples on a trial basis to test the feasibility and usefulness of sampling at the different points.

In making the final selection of measurement points to be sampled, the reviewer should try to avoid measurement points where the claims of interest (returned, disallowed, reduced for reasons other than maximum allowable) are only a small fraction of the total claims. Thus, for example, it is much more desirable to sample a listing of denied claims than a combined listing of approved

and denied claims from which the latter must be selected.

4.4 Step 4: Sample Measurement Points

In this step, samples are taken for each of the measurement points selected in Step 3. The purpose of these samples is to measure the relative impact of the state's controls for the various types of erroneous payments. The reviewer should note the various reasons for reduced, corrected, disallowed, or returned claims at each of the measurement points and should tabulate the number and dollar amount of claims in each category observed.

Extreme care must be taken to insure that the samples are relatively unbiased. For example, it is undesirable to sample over a very short period of time, as such a time interval may yield a biased sample due to the idio-synchrosies of the processing system (e.g. all claims of a certain type may be processed by one individual who was absent during the period of measurement).

The reviewer may wish to consider stratified sampling as a means of improving the accuracy of these tabulations. For example, a 100% sample might be taken of disallowed claims with value exceeding $100, a 50% sample with value between $50 and $100, and a 10% sample with value under $50. In this way, smaller samples may be taken to yield the desired accuracy.

If time does not permit a thorough quantitative analysis, the samples may be used simply to note the most common reasons for denials, returns, etc., without tabulating the number or dollar amount of such claims. In this case, the sampling may be performed more quickly, with less care taken to insure that the samples are unbiased and that there is no duplication of counting. Additionally, the remaining steps may be eliminated.

If any of the control "cutback" reasons are ambiguous (e.g. "denied by medical policy"), it will be necessary to research a sample of such claims to obtain a breakdown of the specific reasons for the cutbacks. For this purpose,

related documents may be gathered from microfilm or other sources, and the reviewer may obtain interpretations from the appropriate claims processing personnel.

4.5 Step 5: Expand Sample to Universe

The reviewer should note the size of the universe from which each sample was drawn and extrapolate all of the sample results to a common basis (e.g. claims and dollars per month). For example, if one sample consists of ten per cent of all eligibility rejects in a two week period, then a factor of 20 would be used to expand the results to a full four-week period.

One method of extrapolation is to make use of claims processing reports to determine the sample size relative to the universe. For example, if a sample consists of 1000 denied claims, and a report indicates that there are 40,000 denied claims in a one-month period, then a factor of 40 could be used to extrapolate the sample results. Such extrapolations should be compared, however, to those computed directly as above, as reports may be inaccurate or the reviewer may not be aware of the correct interpretation of report statistics.

If reports are available which tabulate cutback statistics in more detail, such reports can also be used in conjuction with the sample results. For example, a report may indicate the number of claims denied "by medical policy", while the sampling provides a breakdown of such denials. Again, however, such an approach should only be used after it is determined that the report statistics are reasonable when compared to the sampling statistics by themselves. For example, if the samples indicate, after extrapolation to the universe, that there are 1500 claims per month denied "by medical policy", and the statistical reports indicate 1700, then it would be reasonable to accept the 1700 figure as being more accurate and to use the sample merely to obtain a finer breakdown of the 1700. On the other hand, if the statistical reports indicate 5700, then there is clearly some

inconsistency between the samples and the reports which must be resolved before either may be used with confidence.

Table 1 provides an example of the manner in which the tabulated results may be displayed if all steps of the analysis are carried out. Other examples, some showing less detail, may be found in the assessment reports produced by Control Analysis Corporation for eight states. The first column in Table 1 indicates the disposition for each category of erroneous payments controlled. The second column shows an estimate for the number of claim line items for which the disposition applies, in a four-week period. The third column normalizes this number by the total number of paid line items during a four-week period. The fourth and fifth columns are similar to columns 2 and 3 except that dollars rather than number of claims are tabulated. Finally, for error reasons which are unique to a particular provider type, the sixth column normalizes the dollars denied, etc. by the total dollars paid for that provider type. To illustrate the table, 134 line items were denied because they were billings for pre or post-operative care which should be included in the fee for surgery. This amounted to 0.04 line items for every 100 paid line items in the Medicaid program. The total amount denied was $4.5 thousand, which is $.07 for every $100 paid in the Medicaid program, or $.29 for every $100 paid for physician claims.

5.0 SAMPLE OF UNDETECTED ERRONEOUS PAYMENTS

In Section 4, procedures were discussed for assessing state performance in terms of erroneous payments prevented as a result of existing controls. The purpose of this section is to address the complementary issue of erroneous payments not prevented due to lack of controls or improper operation of controls. This can only be accomplished through a sampling of payments and a laborious audit to determine if the payments are indeed correct. A comprehensive sample, testing

TABLE 1 - SUMMARY OF CLAIMS RETURNED, REDUCED, DENIED, OR DELETED

(Estimates for a four-week period[1])

REASON FOR RETURN, REDUCTION, DENIAL, OR DELETION	DISPOSITION	NUMBER OF CLAIM LINE ITEMS	NUMBER PER 100 PAID	DOLLARS RETURNED, REDUCED, DENIED, OR DELETED (thousands)	DOLLARS PER $100 PAID	DOLLARS PER $100 PAID FOR PROVIDER TYPE
Ineligible Recipient						
Invalid number or not on file	Deny	2908	0.79	$ 54.3	0.83	
Not eligible on date of service	Deny	5534	1.50	89.3	1.37	
Duplicate Claim						
Exact or near duplicate	Deny	1678	0.46	49.8	0.76	
Request provider to verify if duplicate	Return	48	0.01	----	----	
Other sources of payment						
Should be paid by other insurance	Deny or Delete	1216	0.33	71.5	1.10	
Request provider to verify if insurance	Return	24	0.01	----	----	
Medicare should be billed	Deny, Delete or Return	260	0.07	55.2	0.85	
Recipient has excess income	Return	4	0.00	----	----	
Incorrect and/or incomplete claim						
Claim incomplete or additional information needed to process[2]	Return	2540	0.69	----	----	
Request provider to verify apparently erroneous data[3]	Return	596	0.16	----	----	
Request provider to describe ambiguous charges	Return	52	0.01	----	----	
Other payments not allowed						
Not timely filed	Deny or Delete	440	0.12	30.9	0.47	
Incidental surgical procedure (physicians)	Deny or Delete	24	0.01	5.2	0.08	0.33
Multiple surgical procedure (physicians)	Reduce Secondary Procedure	88	0.02	2.3	0.04	0.15
Pre- or post-operative care included in fee for surgery (physicians)	Deny	134	0.04	4.5	0.07	0.29
Service included in total abortion/obstetrical care (physicians)[4]	Deny or Delete	206	0.06	3.6	0.06	0.23
Other incidental services (physicians)[5]	Deny	320	0.09	1.4	0.02	0.09
Sterilization requirements not met	Deny	16	0.00	4.0	0.06	
Denied by Medicare for utilization or other reasons	Deny	368	0.10	3.0	0.05	
Exceeds limitations on office calls, modalities, injections (physicians)	Deny	386	0.10	2.8	0.04	0.18
Exceeds special limitations for providers placed on review (physicians)[6]	Deny	72	0.02	0.9	0.01	0.06
Procedure is inappropriate (physicians)[7]	Change to Lesser Procedure	32	0.01	1.4	0.02	0.09
Lack information previously requested from provider	Deny	41	0.01	1.7	0.03	
Assistant surgeon not allowed for procedure (physician)	Deny	3	0.00	0.3	0.00	0.02
Other services not covered in Kansas[8]	Deny or Return[9]	1298	0.35	13.7	0.21	
Denied after professional review (practitioner)	Deny	280	0.08	2.1	0.03	0.10
Services not covered at state level - bill county	Delete	36	0.01	----	----	
Question circumstances, condition, or necessity[10]	Return	100	0.03	----	----	
TOTAL:		18704	5.08	$397.9	6.10	

[1] The estimates in this table are based on samples of returned, reduced, and deleted claims in March 1976 and samples of denied claims in February 1976. The estimates do not include reductions for reasonable charge or reductions noted by the provider for other sources of payment. During a four-week period in February, 368,640 line items were paid totalling $6.512 million. These figures are for claims processed by Blue Cross/Blue Shield.

[2] Missing data on claim; missing Medicare EOMB; ambiguous diagnosis; procedure not sufficiently specific to price (e.g., require length of laceration or type, strength, quantity of injection or number of tests in lab profile); missing lab invoice for optometry claim; missing date of last optometric exam; charges not broken down; missing description of services; missing tooth chart; submitted on wrong form.

(Footnotes for this table continued on following page...)

Footnotes from Table 1 - (continued...)

3 Most common requests are for physicians to verify procedure code against an apparently inconsistent description, hospitals to verify apparently erroneous calculation of charges/number of days/dates of admission and discharge, and pharmacies to verify unlikely dates of service. Other requests are to verify patient age, accomodation rate, procedure code inconsistent with diagnosis, sex inconsistent with diagnosis, claim data inconsistent with Medicare EOMB, claim data inconsistent with optometry lab invoice, dates of service or procedure codes which would imply duplicate services, illogical place of service, number of follow-up visits, and miscellaneous details of drug dispensed.

4 Visits, routine laboratory tests, etc.

5 Dressings, pelvic exam, ear wash, obtaining lab specimen, taking blood pressure, etc. included in fee for visit; emergency exam included in fee for surgery.

6 Providers placed on pre-payment review as a result of post-payment detection of exceptional utilization or billing practices.

7 E.g., complicated surgical procedure billed without report documenting procedure.

8 Examples of the following non-covered services were found in the sample: crutch or appliance rental; telephone calls; hospital visit on same day as psychiatric visit; autopsy; family-planning lab not allowed with interim visit; over-the-counter drugs; specifically non-covered legend drugs; alveoplasty (dental) not covered same day as extractions; hospital call by dentist; oral hygiene instruction; local anesthetic; emergency prescription by dentist; concurrent care by two physicians; drug quantity exceeds 90 day supply; initial chiropractic exam (payment is made only for treatments); emergency room calls by chiropractor; services by psychiatric social worker or psychiatric nurse; supplies provided by physicians (e.g., bandages, surgical trays, etc.); home health services for patient not homebound; chiropractic services over 90 days without prior approval; dietetic consultation; take home drugs in hospital; occupational therapy billed by hospital; routine foot care.

9 In the case of hospital claims, the provider is requested to resubmit the claim after removing the non-covered service. The amount shown as denied includes only the amount for non-covered services, not the amount returned which will be resubmitted.

10 E.g., why has baby remained in hospital after mother discharged; why late discharge; request operative report; clarify diagnosis or procedure performed; question if glasses lost or broken; question if OB patient referred to another physician.

for all possible types of erroneous payments on a sample of significant size, is beyond the scope of a two-week assessment. However, it is hoped that some limited sampling can provide some quantitative data useful in identifying major problem areas, as well as confirming the presence or absence of controls noted in other phases of the assessment.

One difficulty inherent in such a sampling procedure is that the expected number of errors is relatively small, so that a small sample may not provide a reliable estimate of erroneous payments. On the other hand, a small sample is often useful in uncovering major system problems. Thus, while failure to find a particular type of error is not strong evidence that this type of erroneous payment is well-controlled, failure to find errors of any type is a reasonable indication that controls are effective. At the same time, if a significant number of errors are found in a small sample, this is a good indication of serious problems.

5.1 Claim Sample

It is suggested that a random sample of thirty to forty paid claims be selected to research for appropriate payment. If the state has a quality assurance or internal audit function which includes sampling of paid claims, the reviewers' sample can be coordinated with the state's sample. Alternatively, the sample can be coordinated with the state's Medicaid Eligibility Quality Control Sample if convenient. The sample should include a number of hospital claims, practitioner claims, nursing home claims, and pharmacy claims.

In addition to the random sample, the reviewer may wish to select a sample which is biased toward any particular control deficiencies noted in other phases of the assessment. For example, if the state is found to be lacking in controls for surgery claims (i.e. for incidental surgery, multiple surgery, pre- and post-operative care, etc.), then a sample of surgical claims

might be selected. (One good way to bias in this direction, in a controllable manner, is to sample hospital claims and use the surgery claims, if any, associated with the hospital claims). Similarly, if a state appears to lack good manual procedures for resolving rejected claims, then a sample of manually-resolved claims might be selected.

For each of the paid claims in the sample, the following material should be gathered:

1. Original or microfilm claim document and related attachments,
2. Record of payment made,
3. Listing of recipient paid claims history, if available.

If the paid claims history is not available, it may be possible for claims processing personnel to pull hard copies for all past claims for the recipients in the sample.

Each claim in the sample should be checked to see that payment has been consistent with all significant policy and regulations of the individual state. In the following section, a checklist is provided of items to be verified. This list should be expanded in each state to allow for the most key regulations specific to the state.

Any errors which are detected should be verified with claims processing personnel, and the cause for the error should be determined. That is, it should be determined whether the erroneous payment was made because of a lack of claims processing controls, because of a key entry error, because of a manual processing error, etc. The errors which are detected should also be reconciled with the findings in the other phases of the assessment.

5.2 Claim Sample Checklist

1. Is the recipient eligible on the date of service?
2. Has any spenddown requirement been met?

3. Has spenddown been credited against the allowed amount?
4. If recipient has other insurance, is it indicated on claim?
5. Has insurance been billed if applicable?
6. If payment has been received from insurance, is it reasonable?
7. Is "insurance" information consistent for different claims in the recipient history?
8. Does recipient have Medicare coverage?
9. If so, has it been billed?
10. Have coinsurance and deductable payments been computed correctly?
11. Has Medicare denied any services?
12. If so, have coinsurance and deductible been denied?
13. If a possible accident is indicated, was the accident researched?
14. Was the provider eligible on the date-of-service?
15. Are there any logical inconsistencies between

    diagnosis
    procedure
    sex
    age
    provider specialty
    provider type
    place of service

16. Have Federal regulations for non-emergency sterilization been met?
17. Is claim complete?
18. Is arithmetic correct?
19. Is number of days correctly computed?
20. Are time and units of anesthesia correctly calculated?
21. Was bill submitted within billing time limitation?
22. Have other payments been deducted from the amount payable rather than the amount billed?
23. Are there any unreasonable charges (much less or much more than fee schedule)?

24. If there is no fee schedule for the procedures billed, are there any unreasonable charges?
25. Is the amount paid no more than the maximum allowable?
26. Is the amount paid no more than the amount billed?
27. Are there any hospital private rooms?
28. Are there any other miscellaneous hospital items not covered?
29. Is the claim an exact or near duplicate of a previous claim?
30. Are there any duplicates in associated histories?
31. Is there any improper drug usage (e.g. a refill dispensed before original prescription should be used up)?
32. Are there any procedures which should be combined into a single procedure (e.g. multiple laboratory procedures)?
33. Are there any incidental procedures?
34. Are there any multiple surgeries?
35. If an assistant surgeon billed, was it appropriate for procedure performed?
36. If an assistant surgeon billed, was he paid correctly?
37. Is there any pre- or post-operative care? Pre-natal or post-partum care?
38. Are there any possible duplicates or pre- and post-care from a different type of provider?
39. Are there any consultations after the physician has assumed care?
40. Are there any examples of more than one initial visit?
41. Is referring physician indicated where appropriate?
42. Are there any service limitations violated?
43. Are there any long hospital stays?

44. Are there any readmissions?

45. Are there any violations of major policy or regulations specific to the state?

46. Is procedure code consistent with procedure description?

5.3 Sample of Adjustments and Refunds

Claim adjustments and refunds are often indications of erroneous payments; e.g., a provider returns a check which is a duplicate payment or a payment to the wrong provider. On the other hand, claim adjustments and refunds may frequently result from situations which are outside of the control of the claims processing system; e.g., a provider requests an adjustment after he determines that he billed the wrong procedure or he billed for the wrong patient. At the same time, many, and perhaps most, erroneous payments may never be detected and thus will not result in adjustments or refunds.

A sample should be selected to determine the frequency of adjustments and refunds and to tabulate the various reasons, noting the relative incidence of different types of erroneous payments. As mentioned above, this will result in a lower bound estimate for the magnitude of erroneous payments.

From the distribution of errors, one can draw conclusions about the accuracy of the claims processing system. It can be assumed that an overpayment is less likely than an underpayment to be returned by the provider, particularly if it is less than his original billing; but a large number of errors in underpayments implies a similar number of errors in overpayment. For example, a significant number of claims where payment is less than the correct reasonable charge may indicate problems with the fee profiles, and a likelihood that payments are also being made above reasonable charge.

6.0 SUGGESTED TIME-PHASING OF TASKS

The review methodology discussed above is designed to be performed by two people during a two-week visit to a state. Additionally, it can be expected

that one person-week of advance preparation is necessary and that report-writing will require three person-weeks. These guidelines are applicable for a state which has a single fiscal agent or a single location for the processing of claims. The level of effort would be increased accordingly if there is more than one processing location, since it would be necessary to repeat many of the tasks.

Figure 1 shows the suggested allocation of time for a two-person assessment team during the state visit. During the first half day, the assessment would begin with the orientation session, as indicated in the first questionnaire in Appendix B, to be followed by a "walk-through" of the claims processing system. During the second half of the day, both team members would begin the qualitative analysis of erroneous claim situations by briefly covering the controls present for the major situations shown at the beginning of Appendix A. This will serve to initiate the performance measurement task for team member A and to initiate the qualitative analysis for team member B. In days two through six, team member A will complete the performance measurement task. This will be followed by three days of claim sample analysis and one day to follow up loose ends and participate in the exit interview. Team member B will devote days two through five to the completion of the qualitative analysis of erroneous payment situations. This will be followed by two days to analyze samples of adjustments and refunds, one and one-half days to conduct any additional interviews to complete the questionnaires in Appendix B, and one and one-half days for follow-up and the exit interview.

The above is intended only as a rough guide. At any time that a task is delayed because the appropriate personnel are unavailable, work should begin on a subsequent task. Also, the data needed for each task should be determined at the beginning of the assessment so that it can be made available when needed. For example, in order to obtain recipient histories associated with the sample of

paid claims, it may be necessary to request those histories early in the assessment. Consequently, the sample selection would be made earlier than indicated above.

It is strongly recommended that an evening meeting of the team members be held near the middle of the second week. The purpose of this meeting is to discuss tentative conclusions, begin preparations for the exit interview, and determine those areas where follow-up activity is needed.

T A S K	← D A Y S → 1	2	3	4	5	6	7	8	9	10
Orientation	A,B									
Walk-thru of System	A,B									
Major Erroneous Payment Situations	A,B									
Performance Measurement		A	A	A	A	A				
Erroneous Payment Situations		B	B	B	B					
Sample Paid Claims							A	A	A	
Sample Adjustments and Refunds						B	B			
Questionnaires								B	B	
Follow-up									B	A,B
Exit Interview										A,B

A = Team Member A B = Team Member B

Figure 1 - Schedule of Tasks

APPENDIX A

POTENTIAL ERRONEOUS PAYMENT SITUATIONS

A.1 INTRODUCTION AND SUMMARY

This appendix provides a basic list of potential erroneous payment situations which are generally applicable to all states. These situations may be considered as a "test matrix" which can be used to determine the adequacy of state controls. That is, if the state had a facility for testing system response to fictitious claims, the list of claim situations in this appendix could be used to generate a comprehensive set of test claims which are known to be erroneous and which thus provide a good test of the state's controls. While the submittal of fictitious test claims is beyond the scope of a two-week state assessment, such a list of erroneous situations will alternatively be used as an interview guide to determine the presence or absence of controls for detecting each such situation. That is, one can ask, "what would occur if such a claim were submitted?" The list of erroneous claim situations has been developed for the purpose of such an approach.

During the preparations for the state assessment, the list in this appendix must be custom-tailored to the specific policy and regulations of the state. In some cases, the list indicates that particular erroneous claim situations are conditional on state regulations, and in these cases, the State Plan and provider instructions must be examined to determine whether the claim situation must be changed to fit the particular state situation. Additionally, the State Plan and provider instructions must be examined to determine whether additional claim situations must be added to reflect specific state policy or regulations. For example, if the provider instructions state that "chiropractic visits over two per month must be prior authorized," then an appropriate erroneous claim situation is "Claim for third or greater chiropractic visit in a month, without prior authorization". Note, however, that any conflicts between state regulations and federal regulations should be resolved in favor of the federal regulations.

The reviewer must determine, for each claim situation specified in this appendix and for any additional situations identified as applicable to the state, the controls utilized in the state's claims processing system to prevent an erroneous payment. For each claim situation listed, the results of the investigation should be noted on the worksheet shown: disposition of claim by the normal operating procedures (e.g. claim denied, returned to provider, payment reduced, etc.), method of detection of the situation (e.g. manual vs. computer identification), potential and actual use of edit over-rides (e.g. is this edit active at all times, for all providers, etc.), and any other comments which are applicable. The information summarized on these worksheets will provide the basis for a qualitative evaluation of the edits and audits employed by the claims processing operation.

It must be remembered that it may not be cost effective to fully control all of those situations where control gaps are noted. What is most important is that a formal decision be made by the state on the cost-effectiveness of controlling each situation. (See the questionnaire, "System Evaluation and Planning", for more discussion of this point.) Nevertheless, the reviewer should not attempt to make a judgment on cost-effectiveness but rather should indicate on the worksheet only the presence or absence of controls.

Note that for many erroneous claim situations in this appendix, annotations are given in the right-hand margin. These annotations are designed to aid the interviewer in understanding the claim situation, in ascertaining the appropriate answers, and in documenting any control weaknesses.

Information on the capabilities of normal edits and audits to detect the various erroneous claim situations should be based on interviews with persons familiar with the operating system and on reviews of the system documentation. The personnel interviewed should be sufficiently familiar with the system to answer specifically how each situation is controlled. In some cases, verification that these edits and audits are actually in operation may be made

by observation and by reviewing the listings of rejected, suspended, denied claims, etc. For each erroneous payment category, types of erroneous claims which could possibly be paid without detection should be noted.

The interviewer must ask questions in sufficient detail to satisfy himself that an area is properly controlled. When told that an area is contolled, the interviewer must ascertain exactly how the control is accomplished. Also, the interviewer must be certain that the personnel interviewed clearly understand that the questions are aimed not a determining what policies the state has adopted, but rather what controls are actually in operation to enforce those policies. For example, a state may have a policy to disallow certain types of claims but no control which serves to detect those claims. When asked the disposition of such a situation, the personnel interviewed may state that such claims are not allowed, but such a response reflects policy rather than the realities of the claims processing controls. Thus, considerable caution must be exercised to insure that the responses received are in fact the appropriate responses for the purposes of assessing the control mechanisms present.

The remainder of this introduction will be devoted to a summary of the most critical erroneous payment areas (i.e., those areas which have been found to be most significant in other states) in order to assist the reader in keeping the more lengthy and detailed list of Section A.2 in perspective. The reviewer will find it helpful to briefly review the state's controls in these major areas before carrying out a detailed analysis with the entire list.

CRITICAL ERRONEOUS PAYMENT AREA

Ineligible Recipient (See A.2.1)

- Recipient not on file
- Recipient not eligible on date of service
- Recipient name and number disagree

Ineligible Provider (See A.2.2)

- Provider not on file
- Provider not eligible on date of service

Duplicate Payment (See A.2.3)

- Exact Duplicate
- Near Duplicate

Above Allowed Reasonable Charges (See A.2.4)

- Reasonable charge

Other Sources of Payment Available (See A.2.5)

- Accident liability
- Other insurance should be billed
- Medicare should be billed
- Patient liability; social security

Incorrect and/or Incomplete Claim (See A.2.6)

- Incorrect and/or Incomplete data

Other Payments Not Allowed by Regulation or Policy (See A.2.7)

- Billing time limitation
- Procedure not allowed
- Prior authorization requirements not met
- Hospital admission and length of stay
- Sterilization requirements not met

Multiple and incidental surgeries

Pre or post-operative care for surgery or maternity

Procedure should be billed as a lesser procedure (e.g., initial office visit)

Procedure incidental to another (e.g., IUD after abortion)

Lab combinations

Service limitations over time

Miscellaneous payments not allowed

A.2 POTENTIAL ERRONEOUS PAYMENT SITUATIONS

	Potential Erroneous Payment Situation	Explanatory Notes
A.2.1	Ineligible Recipient	
(1)	recipient not on eligibility file	
(2)	recipient not on file on service date, retroactive eligibility covers service date	Claim should be paid.
(3)	recipient on file, not eligible at any time during service period	
(4)	recipient on file, eligible for only a part of service period	
(5)	recipient on file, date of service is after previously received claim reported death	Is information on recipient death used to update eligibility file? Is it forwarded to welfare office?
(6)	recipient ID number is valid, but name on claim does not correspond to name on file	Are there edits to check recipient number against first and last name? Important for verifying eligibility as well as performing history edits such as for duplicates.
(7)	recipient has valid card, but eligibility has been cancelled	Only of concern if state issues cards less frequently than once a month.
A.2.2	Ineligible Provider	
(1)	provider not on file	
(2)	provider on file, not enrolled during any of service period	
(3)	provider on file, enrolled for only part of service period	

(4) provider on file, but not certified for type of service billed

(5) provider number on file, but name does not correspond

Are there edits to check provider number against provider name? If not, are pre-printed claim forms distributed to providers containing name and identification number?

A.2.3 Duplicate Payment

A.2.3.1 Exact Duplicate Claims

(1) same date, provider, recipient, service type, charge, procedure and/or diagnosis (for dental--same tooth) as previously paid claim

(a) 2nd claim received in a different edit processing or check-writing cycle

(b) 2nd claim received in same edit processing or check-writing cycle

(c) 2nd claim received on same invoice

(2) same as (1), previous claim suspended

The significance of this situation depends on the types of override codes used to force through a pended claim.

(3) same as (1), previous claim denied

Of particular concern when previous claim went through a considerable review prior to denial.

A.2.3.2 Near Duplicate Claims

The following situations are intended to refer specifically to cases where an actual duplicate billing has occured. However, these situations overlap considerably with situations that are not actual duplicates, but may be some other type of erroneous payment situation. For example, 7(b) could be a real duplicate bill for the same service billed under an individual number, or it could be a case of concurrent care by two physicians.

In essence, these situations are detected by a "combination edit", in which certain combinations of procedures, provider, service dates, etc. are considered suspect. Refer particularly to Section A.2.7.1 later.

(1) same as exact duplicate except a different but comparable procedure is listed (e.g., different types of office visits, different variations of the same surgical procedure, or misinterpretation of a description in a procedure code manual resulting in a billing for both a basic procedure and a listed variation)

(2) same as exact duplicate except dates of service are overlapping or different but in close proximity

Dates in close proximity would be of interest, for example, for expensive surgical procedures.

(3) same as exact duplicate except different provider

(4) same as exact duplicate except different charge

(5) same as exact duplicate except different provider service type, e.g.,

- (a) claim for services by salaried staff of provider (for example, physician on salary included in inpatient hospital costs, bills separately under his own provider number)
- (b) physician bills for services administered in clinic, group practice, or outpatient facility when latter also bills
- (c) pharmacy charges separate from inpatient, SNF, or outpatient facility
- (d) physician bills for analyzing lab (or x-ray) results which are included in laboratory (radiology) charges

(6) same as exact duplicate except different recipient number

Are there controls to insure that there are no duplicate eligibility records for the same date, e.g., due to change in county or aid category? Are there controls to insure that claims are paid under the correct eligibility number so that duplicates will be detected? Problems can occur when eligibility overrides are used.

(7)	various combinations of the above, e.g.,	
	(a) two practitioner claims for a similar major surgical procedure within a short period of time (possibly from different providers)	
	(b) two practitioner claims for visits (possibly different types) on the same day (possibly from different providers)	
	(c) two claims with different charges for overlapping dates of service	
(8)	a fee-for-service claim for a recipient enrolled in a pre-paid health plan which provides the given type of service	Applicable only if the state contracts with PHP's.
A.2.4	Above Allowed Reasonable Charges	
(1)	claim amount exceeds maximum limits on fee file	Medicaid should not pay more than maximum limit. Are there any claim types for which there are no fee files?
(2)	amount claimed does not exceed limits on file but these limits are higher than in source documents or by intended method of calculation	What procedures are there to insure accurate data on fee file? Is the file sampled for accuracy?
(3)	claim amount exceeds Medicare payment for the same service by the same provider	Federal regulations prohibit paying more than Medicare limit.
(4)	Title XVIII claim for deductible and co-insurance where original amount billed under Medicare exceeds allowable Medicare amount	Medicaid should pay Medicare allowed amount less Medicare payment, NOT billed amount less Medicare payment.
(5)	claim amount is less than fee amount allowed by schedule	In this case Medicaid should pay claimed amount.
(6)	adjustment (supplemental payment) to original claim results in combined charge exceeding limits on fee file	Adjustments are often handled differently from original claims, and may not be subjected to all of the usual edits.

(7)	claim for procedure after a rate change	Claim for service rendered prior to new rate should receive old rate. Does fee file have provision for different rates on different service dates?
(8)	duplicate claim which shows lower amount billed than original claim paid	Medicaid should pay lower amount, request refund of original.
(9)	claim amount exceeds limit on fee file and there is a partial or total payment by recipient or other insurance	Other payment should be deducted from reasonable charge, not billed amount.
(10)	amount approved on prior authorization exceeds amount in fee schedule	Are payment amounts authorized? If so, are they edited against the fee file?
(11)	pharmacy claimed wholesale cost exceeds actual cost	Is there a fee schedule for drugs? If not, are there spot audits of pharmacies?
(12)	pharmacy claim exceeds price paid by public for same item	Can arise where "mark-up" is less than dispensing fee. Are there spot audits of pharmacies?
(13)	incorrect room rate for institutional claims	Is there a file of accomodation rates which is checked during processing?

A.2.5 Other Sources of Payment Available

Federal regulations require that all other sources of funds be exhausted before Medicaid benefits may be applied. There should therefore be some method or methods of detecting the possibility of other sources, such as other medical insurance, accident liability, etc., as well as methods for following up on these possibilities or ensuring that the provider has done so.

A.2.5.1 Accident Liability

(1)	an accident related procedure or diagnosis is listed but no third party liability information is received	Is claim referred for follow-up?
(2)	provider indicates accident on claim form but there is no payment by third party or payment by third party is incorrect amount	Are accident cases referred to for follow-up?
(3)	Service resulted from an accident but there is no indication on the claim	Does the claim form specifically ask if care is related to an accident?

A.2.5.2 Other Insurance

(1)	no indication of other insurance on claim; eligibility file shows other medical resources	Is insurance data maintained on the recipient file? How specific is information on other insurance? Is this information printed on the recipient's identification card? Can edits distinguish types of care where there is no coverage? Are claims referred for follow-up if recipient has coverage?
(2)	other insurance pays incorrect amount or incorrectly states there is no coverage or provider states there is no coverage	Is detailed policy coverage data maintained for most common policies? Does state require copy of insurance correspondence or remittance? Does state periodically audit insurance payments? Note, provider might incorrectly state there is no coverage because the recipient must satisfy a deductible. In this case, it is important that Medicaid payments be credited towards the deductible.
(3)	some indication of other insurance on invoice (box checked or credit taken) and eligibility file shows no insurance	Is there a clear yes/no question on the claim form relating to other insurance? Is the data used to update the eligibility file? Are other similar claims audited for possible application of this insurance?
(4)	claim were eligibility file or claim indicates other insurance and the amount paid by the insurance company is unreasonably small	Is there a reasonableness edit? Is detailed policy data maintained?
(5)	other insurance billed but not yet paid, claim paid by Medicaid; no insurance payment received after significant time has elapsed	Does state follow-up to conclude that other insurance should not pay, or if it should, to make collection?
(6)	other insurance billed not but yet paid; provider has not allowed sufficient time to pass before billing Medicaid	For states which permit providers to bill Medicaid when payment has not been received from other insurance within a specified time.

A.2.5.3 Medicare

(1) recipient eligible for Medicare (A and/or B) and Medicare has not been billed	Is Medicare coverage indicated on recipient file?
(2) claim for recipient over 65, no indication of Medicare coverage	If no claim edit, is there a frequent, i.e., monthly, processing of eligibility files to extract such individuals?
(3) Medicare co-insurance/deductible for payments not ordinarily allowed by Medicaid (e.g., for reasons of coverage or service limitation)	Will Medicaid pay co-insurance and deductible?

The following three situations usually apply only when provider submits bill, rather than having it directly transmitted from Medicare carrier.

(4) Medicaid's portion of Medicare co-insurance/deductible incorrectly listed	Is there sufficient information on claim to check correctness of amount? Is Medicare EOMB required?
(5) cumulative Medicare deductible for Part B services exceed $60.00	
(6) Medicare co-insurance/deductible for service disallowed by Medicare (e.g., for overutilization)	Not really a problem of other insurance, but included here for discussion convenience.

A.2.5.4 Patient Liability

(1) claim amount includes the last portion of patient's spenddown requirements	Is claim prorated? If so, how?
(2) date of service is prior to date on which spenddown requirement was met	
(a) claim was used as part of spenddown requirement	Claim should not be paid.
(b) claim was NOT used as part of spenddown requirement	What procedures are used to handle these claims which ARE payable?

(3) incorrect patient contribution (including social security) is deducted on a SNF or ICF claim for a full time resident	Incorrect deduction includes the case where deduction is taken when it shouldn't be. Are claims edited against a file containing data on required patient contribution?
(4) claim for services provided prior to death of a medically needy recipient when recipient leaves an estate capable of payment	
A.2.5.5 Co-Payment	
(1) provider increases fee to compensate for co-payment	Only applies in a state that requires a co-payment from a recipient.
(2) provider fails to deduct co-payment	Does system deduct co-payment automatically?
A.2.6 Incorrect and/or Incomplete Claims	
(1) incomplete claims, including invalid (not computer-acceptable) codes submitted or keyed, e.g.,	
(a) ID number missing	
(b) charge not given	
(c) initials or signatures of preparer missing	
(d) invalid, missing, or out of range data	
(e) additional information or documentation needed	
(2) unreasonable entries submitted or keyed, e.g.,	
(a) unreasonable charges, such as	
(i) charge differs from fee file by significant amount	Are there "variance" edits to detect such situations?
(ii) no fee on file, but charges seem ridiculous (e.g., ancillary charges)	Are there reasonableness limits for such charges?
(iii) implied late discharge fee is unreasonable	Can a hospital bill a late discharge fee by submitting charges greater than days x per diem?

(b) unreasonable time sequence, such as	
(i) end service date not sequential to start	
(ii) date of discharge not sequential to date of admission	
(iii) claim process date not sequential to end service date	
(iv) date of discharge not within service period	
(c) unreasonable quantities, such as	
(i) ridiculous number of services, days or visits	Are there reasonableness limits?
(ii) service period less than number of visits/accomodation days	
(iii) incorrect dispensing unit of measure on pharmacy claim (e.g., ounces rather than tablets)	Are there variance edits on amount charged versus amount allowed for the specified number of units?
(iv) subtotals don't balance as submitted or keyed	
(v) charge per service or day multiplied by number of services or days does not equal total charges	
(3) incorrect procedure submitted or keyed and procedure code not on file	
(4) incorrect drug code which is (by chance) a valid drug code on file	Can be controlled through use of a check digit.
(5) incorrect ID number of provider or recipient submitted or keyed and ID number is (by chance) valid	In this case ID number would not correspond to name. See under eligibility in Section A.2.1 (6) and A.2.2 (5).
(6) procedure incompatible with:	
(a) diagnosis (e.g., appendectomy for tonsillitis)	
(b) age (e.g., obstetrical delivery for 5-year-old)	

(c) sex (e.g., obstetrical delivery for a male)

(d) specialty (e.g., open heart surgery by a gynecologist)

(e) provider type (e.g., heart surgery by a dentist) — Can the system detect if a dentist bills on a physician form?

(f) past procedure (e.g., maternity care after hysterectomy, extraction of same tooth as previously, etc.)

(g) written procedure description — Do qualified personnel check procedure code against the description?

(h) place of service (e.g., heart surgery in the office)

(7) miscellaneous key entry errors — Is there verification? Check digits? Quality assurance? Or are there sufficient cross checks and logical checks as above?

(8) claim inconsistent with supporting documentation (e.g., inconsistent with Medicare EOMB, or procedure inconsistent with operative report, or ancillary charges inconsistent with itemized billing)

A.2.7 Other Payments Not Allowed by Regulation or Policy

A.2.7.1 General

(1) non-covered service which has a prior authorization — Will edits for non-covered services be overriden?

(2) disagreement between claim and prior authorization

(a) recipient ID does not match

(b) provider ID does not match

(c) procedure code does not match

(d) diagnosis code does not match

	(e) dates of service do not match authorization dates or authorization has expired	
	(f) claim amount exceeds authorized amount	
	(g) no prior authorization obtained for service requiring such	
(3)	service not billed within billing time limitation	(Note: limitation cannot exceed Federal limit of 24 months)
(4)	claim for service which is rendered free to general public (e.g., testing for venereal disease)	If these procedures are not allowed, can they be distinguished (e.g., through separate codes) from allowed procedures such as office visits?
(5)	claim for broken appointments	Prohibited by Federal regulations. If billed, can these be distinguished from allowed procedures? Is there a separate code for broken appointments?
(6)	claim for services which are allowed for one but not both of the medically needy and categorically needy groups	Depends on policy in State under review.
(7)	claim for sterilization of recipient	Prohibited by Federal regulations.
	(a) under 21 years of age	
	(b) legally incapable of consent	
	(c) without written consent	
	(d) performed within 72 hours following consent	
(8)	miscellaneous non-covered services	If billed, can these services be distinguished from allowed services which may be related? One method is to establish separate procedure codes for non-covered services and to deny claims with these codes. Such codes eliminate ambiguity.

A.2.7.2 Physician

(1) procedure claimed is inappropriate (e.g., a more expensive procedure or more extensive visit than appropriate)	Can certain procedures be made to suspend automatically? Are there post-payment edits on certain potentially-abused procedures? Is procedure code matched with description? Are there limitation edits which detect initial office visits? Are there requirements for supporting documentation when extensive procedures are billed?
(2) claim for an item not listed in fee schedule	Some states may allow payment upon suitable justification such as a report.
(3) procedure code requires report and one is not submitted	
(4) physician claims for hospital visit during portion of a hospital stay which was previously disallowed or reduced (e.g., for exceeding length-of-stay restrictions)	Are hospital visits also disallowed?
(5) assistant or co-surgeon bills for a surgical procedure which does not warrant more than one surgeon	Does procedure code file indicate if more than one surgeon allowed?
(6) assistant surgeon bills without indicating assistant status (e.g., through use of procedure modifier code or type of service code)	Is claim detected as a near duplicate of primary surgeon's claim?
(7) assistant surgeon bills correct percentage of his customary full surgical fee, does not indicate assistant status, and his full fee is higher than full maximum allowable	Is claim detected as a near duplicate of primary surgeon's claim?
Items (8) through (15) are all of the general type in which more than one service is involved in a combination that could imply an erroneous payment.	
(8) procedures incidental to major surgery (e.g., biopsy, endoscopy, more than one procedure in an incision) performed by	
(a) same physician	

(b) other physician	
(9) one procedure incidental to and included in another (e.g., insertion of IUD in conjunction with abortion; blood pressure reading in conjunction with an office visit; pelvic examination in conjunction with an office visit)	
(10) multiple surgery (secondary surgery should be paid at lesser amount)	
(11) pre or post-operative care associated with major surgery or maternity performed by	Pre and post-care is defined specifically by state policy. Is there a distinction between pre and post-care in the hospital and pre and post-care in the office?
(a) same physician	
(b) other physician	
(c) other provider type (e.g., hospital outpatient department)	
(12) several single procedures which should be paid at rate of one inclusive procedure (e.g., laboratory panels)	Sum of parts would be more expensive than the single inclusive procedure.
(13) consultation after physician has "assumed care"	Are excessive consultations within private clinic or group practice also controlled?
(14) second consultation within specified time period	
(15) second initial office visit within specified time period	
Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.	

(16)	follow-up hospital visit billed on same day as minor surgery by	
	(a) same physician	
	(b) other physician	
	(c) other provider type	
(17)	more than one physician billing for regular and continuing patient care	
(18)	medical procedures including surgery considered experimental or not generally employed by medical profession	
(19)	cosmetic surgery	
(20)	elective surgery	
(21)	claim violating frequency limitations on visits or other services	
(22)	claim received where provider fails to use procedure modifier code or type of service code to indicate special billing situation (e.g., multiple surgery, co-surgeon, surgery follow-up care only, "professional component" only, etc.)	For example, what procedures are there to detect a co-surgeon who fails to indicate his co-surgeon status through use of a modifier code?
(23)	claim received where provider has made improper use of a procedure modifier code or type of service code which could result in overpayment	Are claims with modifiers which result in extra payment suspended for review?
(24)	house calls	
(25)	routine physical or immunization	If these procedures are not allowed, can they be distinguished (e.g., through separate codes) from allowed procedures such as office visits?
(26)	claim where anesthesiologist includes base units	Only applies in states in which time units are billed and system automatically adds base units.

(27)	referring physician not indicated	Only applies when required by state regulations.
(28)	claim for services provided as anesthesiologist without name and license of primary operating physician	Only applies when required by state regulations.
(29)	assistant surgeon bills without naming primary surgeon	Only applies when required by state regulations.
A.2.7.3 Inpatient		
(1)	private room without certification	Either on claim or in hospital records. If the latter, does an audit confirm?
(2)	whole blood when	
	(a) other sources available, or	
	(b) replaced	
(3)	inpatient charge where admission not certified by physician as medically necessary	Does a field audit confirm certification of admission?
(4)	luxury items or other non-covered charges	Are such items detected if included in a "catch-all" ancillary category (e.g., "other")?
(5)	personal care	
(6)	inpatient stay exceeds length-of-stay guidelines	Depends on specific state policy. If a stay is reduced, are ancillary charges also reduced?
(7)	significant inpatient stay for minor illness	Most applicable for states which have uniform or no length-of-stay requirement.
(8)	hospital admission for diagnostic purposes which could be carried out in a doctor's office or on an outpatient basis	For example, as indicated by little or no drug charges.

(9) readmission (any hospital) within specified time after discharge, to circumvent length of stay guidelines	
(a) same or similar diagnosis	
(b) different diagnosis	
(10) split billing of hospital stay (stay is divided into two or more parts for billing purposes) where total stay exceeds length of stay guidelines	
(a) admission date correctly given on each split claim	Does length-of-stay edit compute number of days based on admission date?
(b) admission date on second claim is incorrectly given as "from" date of service	Is there a history edit to detect an earlier date?
(11) claim for institutionalized patient on day of admission as well as day of discharge	Are number of days checked against admission and discharge date?
(12) excess time between date of surgery and hospital admission date	
(13) surgery set-up charges on inpatient claim when surgery cancelled (e.g., billed under operating room ancillary charges)	
(14) specific diagnoses for which hospital stay not justified	
(15) short-term psychiatric or TB services	
A.2.7.4 Long Term Care	
(1) claim for SNF or ICF where patient admission not certified	How is payment information reconciled with field reviews?

(2) SNF or ICF charge after patient certification discontinued	Are there procedures for providing the claims processing system with information on which patients have been recertified and for what level of care? Are there audits to check for such recertifications? Are there procedures to ensure that the results of medical and professional review are implemented (retroactively if appropriate) in the claims payment system?
(a) end of certification by non-recertification	
(b) end of certification or change in level of care determined by state medical or professional review	
(3) private room without certification	
(4) level of care billed for a particular patient does not agree with level of care currently authorized	
(5) claim for luxury items (radio, T.V., elaborate personal care)	
(6) a claim for a recipient who is out of the nursing home for:	
(a) therapeutic home visit	Federal regulations allow 18 home visit days in a 12 month period. Are there controls to determine if these days are exceeded? If no claims processing controls, are there on-site audits for patient absences?
(b) transfer to another home	
(c) acute hospitalization	Federal regulations allow 15 "bed-hold" days for a single hospital stay.

(d) discharged or deceased	Are patient records reconciled with claims payments?
(7) claim for recipient not receiving an in-facility review	Are there procedures (e.g., through a turnaround document) for providing the claims processing system with information on which recipients have been reviewed? Alternatively, do the review teams have access to payment records indicating for which patients there have been claims submitted.
(8) drug charges in SNF or ICF	Depends on state regulations. If such facilities can bill drug charges, the same control as for pharmacy claims should apply. See CFR 250.30 (b)(2)(iv).
(9) SNF or ICF services not customarily provided for in these facilities	
(10) a claim for a long-term care recipient who receives an inordinate amount of ancillary services or services not consistent with diagnosis	

A.2.7.5 Pharmacy

Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.

(1) specifically non-covered legend drugs	
(2) charge for maintenance drugs in less than minimum quantity	
(3) repeat prescription or refill where original was for a quantity less than a minimum supply	
(4) over-the-counter (OTC) drugs	
(5) drug refill too early for previous quantity to be consumed	

A.2.7.6 Dental

Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.

(1) any of the following services more than once within a specified time period:	Limitations specified by individual state regulations.
(a) initial exam	
(b) periodic oral exam	
(c) prophylaxis	
(d) topical fluoride application	
(e) diagnostic x-rays	
(f) full series x-rays	
(g) restorative work on same tooth surface	
(h) patient education	
(i) other services with limitations over time	
(2) dental laboratory services (dentist pays)	
(3) administration of analgesia, local anesthesia, or regional block anesthesia in conjunction with operative or surgical procedures	When surgical fee is intended to include anesthesia.
(4) hospitalization for dental work	

A.2.7.7 EPSDT

(1) screening services for recipient over 21	
(2) screening service by a provider not certified specifically for screening	

(3) screening service without referral made for abnormality found	
(4) screening service with fewer than the required number of examinations	
Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.	
(5) second screening service claim within specified time	
(6) screening services not requested by local health office	
A.2.7.8 Optical	
Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.	
(1) more than one routine eye examination and/or change of glasses in a specified time period	
(2) eye exercises (orthoptics)	
(3) charge for lens greater than lab cost to provider	Is copy of invoice required for verification?
(4) multiple pairs of glasses for the same individual	
(5) lens replacement filled when refraction correction is less than some specified amount	Actual change in correction must be determined from state regulations.
(6) purchase or repair of wire frames	
(7) contact lenses	
(8) tinted lenses	
(9) sunglasses	

A.2.7.9 Other Services

(1)	tuberculosis facility for recipient less than 65	
(2)	mental facility for recipient less than 65	
(3)	long-term TB or psychiatric patient in institution other than TB or certified mental institution	
(4)	independent laboratory services not ordered by physician	Does claim require name and license number of referring physician?
(5)	home health services not properly certified for patient	

Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.

(6)	emergency transportation without documentation	
(7)	home health agency services provided to a patient in a hospital, SNF, ICF, or government institution	
(8)	home health aide claim submitted by member of recipient's immediate household	What controls are exercised on enrollment of such providers?
(9)	domestic or housekeeping services	How can such services be distinguished from home health services?
(10)	day care services	How can such services be distinguished from home health services? from hospital outpatient care?
(11)	"meals on wheels"	How can such services be distinguished from home health services?
(12)	custodial care	How can such services be distinguished from home health services?

(13) psychological testing for educational diagnosis, school or institutional placement, or on court order

(14) physical or speech therapy claim without proof of medical referral by physician

(15) speech, physical or occupational therapy outside of institution

(16) remedial education

(17) services of Christian Science nurses or spiritual healers

(18) private duty nurse or attendant

(19) chiropractor services

(20) audiologist services

(21) psychologist or social worker services

(22) routine foot care

(23) family planning services or supplies

(24) medical equipment and supplies

(25) prosthetic devices

(27) false teeth, wigs, artificial breasts, hearing aids

APPENDIX B

QUESTIONNAIRE WORKSHEETS

The questionnaires in this appendix are designed to provide additional information on the state's ability to prevent erroneous expenditures. It is intended that they be left as the final phase of the assessment (with the exception of the Orientation questionnaire) and, as such, many of the questions will be answered in the course of the other analyses. Thus, the time required to complete this phase will be minimal.

The questions are not intended to be asked verbatim to state personnel. Rather they should be considered as a checklist to the reviewer to assure that he is satisfied with the state's procedures in each area. Also, the questions are not meant to limit the scope of investigation. If potential problems are observed in an area, additional follow-up questions should be asked.

Questionnaire Worksheets are provided in the following areas:

1. System Orientation
2. Bypass and Override Procedures
3. Financial System
4. Controls on Cost-Reimbursed Providers
5. Post-Payment Edits
6. Information Feedback
7. Claim Format
8. Personnel and Training
9. File Maintenance
10. Quality Assurance Procedures
11. System Evaluation and Planning

QUESTIONNAIRE WORKSHEET

System Orientation

An attempt should be made to answer many of these questions before the state visit.

1. (a) What group or organization has responsibility for

claims processing operation?

computer processing?

medical review of claims?

post-payment review?

quality assurance of claims processing?

(b) Are there exceptions for

certain claim types?

geographical locations?

(c) Is all processing and review performed in one location?

2. Is a claim a complete invoice or a line item on an invoice?

3. How many claims per year? Dollars paid? Obtain reports which break these figures down as follows:

Total:

Inpatient hospital:

Outpatient hospital:

Physician:

Drugs:

Dental:

Nursing home:

Other:

4. How many recipients?

On recipient file:

Active (open) recipients:

5. What is the typical processing time for claims which do not require review?

For claims requiring review?

6. (a) Is the computer used for preparation of checks and remittance advice:

(b) Does remittance advice include:

Recipient name or ID?

Date of service?

Procedure code (or description of item)?

Reason for denial or reduction?

Status of unpaid (pended) claims?

7. (a) Is the computer used for claim control?

   (b) During processing?

   (c) After processing?

   (d) After payment?

8. (a) Is there a history of paid claims?

   (b) How many months of history are kept?

   (c) Does it include denied claims?

   (d) Does it include pended claims?

9. (a) Does the claims processing system have access to an eligibility file?

   (b) Who updates file?

   (c) Is there a centralized welfare file?

   (d) How often are cards issued?

   (e) Does the eligibility card clearly indicate the expiration date?

   (f) If eligibility cards are issued less frequently than once each month, is the eligibility redetermination process timed to coordinate with card issuance?

   (g) Are there procedures to hand-pull cards in cases where eligibility has been cancelled after the cutoff date for card issuance?

   (h) Are payments made to a provider as long as a recipient shows a valid card, regardless of whether recipient's eligibility has been cancelled?

(i) If so, does the state compute the amount of such payments and exclude this amount from its claim for federal matching funds?

10. (a) Is there a computer or manual file with data on:

Other insurance?

Medicare?

Spenddown requirement?

(b) How is data obtained?

(c) How is it updated?

(d) Is this information on recipient ID card?

If not, how is provider informed of other insurance?

(e) What is the system for processing claims where the recipient has other insurance?

11. Does the recipient file (eligibility) contain any "historical" data that would imply limitations on services?

Dental information (teeth missing, etc.)?

Medical (hysterectomy, appendectomy, tonsillectomy, etc.)?

Coverage (number of hospital days used, Medicare deductible, etc.)?

Other?

12. (a) What happens to claims that fail edits (and need manual review)?

1. Reasonableness edits (e.g. key-punch error)?

2. Non-historical edits (e.g. recipient not eligible)?

3. Historical edits (e.g. pre- and post-care with surgery)?

(b) How are these different types of claims re-entered?

13. (a) Is the history used during claims processing?

(b) For duplicates and near duplicates?

(c) For edits to detect invalid combinations of procedures (e.g. post-operative care with surgery)?

(d) For service limitation edits?

(e) Other edits?

(f) Is related history printed out with erroneous claims?

(g) Is history available on-line?

(h) If not, what time is needed to obtain history?

(i) Describe the system for obtaining histories.

14. How are Title 18 crossover claims processed? Is sufficient information provided to facilitate normal claim editing, e.g., for duplicate claims?

15. (a) What is the system for processing claims requiring prior authorization?

(b) How is the prior authorization itself processed?

16. Are claims edited for accident liability?

17. (a) Is there any pre-screening of claims before computer processing?

(b) Is it practice to exception-route claims?

(c) If so, what situations?

(d) Are there computer back-up audits for these situations?

18. (a) Is it a practice to review more intensively any claims which are significantly expensive?

(b) What procedures are employed?

19. Are there edits on facility ancillary charges?

20. Are there edits on length-of-stay?

21. When a "catch-all" procedure is billed, is it automatically reviewed manually?

22. (a) Are there any pre-paid health plans?

(b) If so, are claims edited for duplicate billings by PHP and fee-for-service provider?

23. (a) Describe the mechanism for distinguishing different members of a group practice.

(b) Is identity of the group maintained?

(c) Are there any edits to control excessive internal referrals among providers in a group practice?

24. (a) Are customary charges maintained for each physician?

(b) Are prevailing charges maintained for each region of the state?

(c) Is there a maximum fee schedule?

(d) Statewide or by region?

25. Is there a file of daily room rates for:

    Inpatient hospitals?

    Nursing homes?

26. Is there a file of patient contributions in nursing homes?

27. (a) Is there a fee file for drugs?

    (b) How is the fee determined?

    (c) Is there an individual dispensing fee for each pharmacy?

    If so, how is it determined?

28. Describe reports available to monitor the performance of the control system edits.

29. Are any reports produced to highlight unusual provider practices or recipient utilization?

30. (a) List all possible statuses that a claim can have (approve, suspend, deny, return, etc.)

    (b) At what points in the processing, and by whom, are the various statuses assigned?

    (c) Can a deny status be computer-assigned? If so, for what reasons?

    (d) What statuses are assigned for each of the major erroneous payment situations listed in Section A.1?

31. It is the state's intention to control all possible areas of erroneous payments or to selectively omit controls in certain areas?

32. (a) What are the best features of the system?

    (b) What are the weakest features of the system?

QUESTIONNAIRE WORKSHEET

By-pass and Override Procedures

The purpose of this questionnaire is to determine whether there are some circumstances in which erroneous payments might be made as the result of by-passes or overrides which circumvent normal claims processing edits. Problems which have been observed in some states include:

a) A state may by-pass edits as a means of reducing processing backlogs.

b) Some systems, when a claim is suspended, do not list all reasons for the suspension. As a result, the claim may be approved with a force code entered which overrides edits for potential errors not apparent to the claim reviewer. This problem is diminished if all exception reasons are listed at once or if override codes are very specific to particular edits.

c) Some systems, when performing edits related to recipient history (e.g. duplicate edits) do not consider suspended claims as part of history. Consequently when a suspended claim is approved, it will not have been exposed to all claims processed in the time between suspension and approval. Consequently, if a force code is used, erroneous payments, e.g. duplicate payments, may result. This problem is particularly serious when override codes are very general (e.g. override all edits).

1. Who has authority to institute a by-pass (edit turned off)? What review, controls, and record keeping is used?

2. Historically, document the extent to which by-passes have been used. Review records of such instances in the recent past.

3. Are all edits active at all times, or are some active only in a sampling or periodic mode? If so, describe those to which this applies. What review, control, and record keeping is used?

4. Explain how claims suspended or claims flagged by the computer to be returned to the provider are re-introduced into the claims processing system after manual review has indicated that the claim should not be denied or returned for the particular reason indicated. Describe the use of override or force codes (input flagged to avoid edit).

5. When a claim is corrected after failing an edit or audit, is it then subjected again to all other edits and audits? If the failed edit is overriden, how specific is the override? If claim data is changed by a reviewer, is this changed data subjected to the usual edits and audits? Repeat this question for each cycle of processing (e.g, single-claim processing and history processing, if carried out in separate computer runs).

6. When a claim fails (i.e., is given any disposition other than pay status) are all reasons for all possible exceptions printed out? (Note, it is equally important that the reviewer be aware of any "denial" reason that was overriden by a "suspend" reason.) Repeat this question for each cycle of processing.

7. When a claim is suspended for manual review is there a computer printout of the claim information? If not, how does the reviewer ascertain that the original invoice information agrees with the information entered and stored in the computer? Without such a match of information, the reviewer could unknowingly approve a claim entered erroneously.

8. During the processing of history edits, is a claim edited against all claims preceding it in processing, including denied claims and claims not yet resolved (i.e. not yet approved or denied)? It is important to edit against claims not yet resolved so that when the latter are approved they will have been exposed to claims processed since their initial processing. It is important to edit against denied claims so that claims which were difficult to resolve will not require duplicate effort when identical claims are re-submitted. Also, such editing avoids the possibility of overlooking a denial reason which was established for the original claim.

QUESTIONNAIRE WORKSHEET

Financial System

This questionnaire is concerned with the use made of the claims processing system to handle payments or collections which are apart from the normal processing of original claims. The main questions at issue are

a) whether the state has the ability to apply manual or computer procedures to prevent payment to a provider delinquent in paying funds owed the state; and

b) whether the system for processing claim adjustments includes the normal claims processing controls for preventing erroneous payments.

1. Can the provider record show a non-zero balance? A negative balance? A positive balance?

2. Is the balance shown on a provider record used to adjust payment for subsequent claims processed? A negative balance? A positive balance. If not, what methods are used to eliminate a non-zero balance?

3. Is a negative balance created

   (a) when the provider submits an adjustment?

   (b) when the state audit group determines provider was overpaid?

   (c) other?

4. Is a credit created

   (a) when the provider submits an adjustment?

   (b) when the state audit group determines provider was underpaid?

   (c) by a voided, cancelled, destroyed, or returned check?

5. Is a review of negative provider balances made regularly? How often? By whom?

6. Describe the extent to which adjustments are subjected to normal claims processing edits.

7. Are provider refunds checked to insure that they have been computed correctly? For example, if a provider refunds a payment by a third party, the third party payment should be deducted from the amount payable by Medicaid, not from the amount originally billed by the provider for the service.

QUESTIONNAIRE WORKSHEET

Controls on Cost-Reimbursed Providers

For every type of provider which is cost-reimbursed, the state devises a formula setting out the procedures for determining the amount of reimbursement. Such a formula typically involves three elements: an audit of provider costs, a determination of approved Medicaid charges or utilization, and an equation to pro-rate costs on the basis of approved charges or utilization. For example, a hospital accommodation cost reimbursement might be determined by first establishing total accommodation costs via an audit, secondly establishing total approved Medicaid accommodation days, as per claims processing statistics, and thirdly computing allowed Medicaid costs by multiplying total costs by the ratio of Medicaid days to total days. Similarly, reimbursement for an ancillary department might be determined by first establishing total ancillary costs via an audit, secondly establishing total approved Medicaid ancillary charges, and thirdly computing allowed Medicaid costs by multiplying total costs by the ratio of Medicaid charges to total charges.

Erroneous payments may result if

a) costs are not computed correctly,

b) approved utilization or charges are not computed correctly, or

c) the claims processing personnel, unfamiliar with the cost-reimbursement formula, do not apply adequate controls for cost providers because they mistakenly believe that such controls are irrelevant in view of the cost audit and settlement.

Of these three causes for erroneous payments, the state assessment focuses on the latter two. Cost auditing procedures are investigated only in a broad sense for background when necessary. The focus of the following questions is

to determine whether the proper data is accumulated during claims processing and is made available for use in the reimbursement formula. Additionally, the reviewer should recognize the importance of claims processing controls on cost providers, such as edits for duplicate payments, length of stay, key entry errors, etc., as such controls do affect the ultimate reimbursement. Evaluation of such controls is of course the subject of the potential erroneous payment situations given in Appendix A.

1. Which provider types are cost-reimbursed?

2. Is there a final year end settlement? If so, what information is the settlement based on? What is the formula or method used for determining the settlement? What paid claims information is used? What provider records are used? Is information from both reconciled? Is information on denied and adjusted claims incorporated into the settlement? If refunds are received, e.g. after an erroneous payment, are accumulations on allowed charges/days modified appropriately? If there is no settlement but rather the audit serves to establish reimbursement rates for the following year, answer the above questions as they relate to determining the reimbursement rate.

3. Is sufficient claims processing data used in the settlement to arrive at a correct result? Is the data found to be reliable?

4. For cost providers, is there sufficient information on the claim form to verify reasonableness of the charges and to perform normal claim editing such as duplicate checking and other editing for proper services or billing? Is such editing performed (see also erroneous claim situations in Appendix A)?

5. If cost reimbursement is not on a department pro-rated basis, are there services included in the per diem rate that are more likely to be used by private patients than by Medicaid patients (e.g. private rooms)?

6. Are charges for non-covered services (e.g. telephone, luxury items) excluded from the accumulation of allowed charges and excluded from allowed costs in the settlement?

7. What audit procedures are used to insure that charges for Title 19 patients are not higher than for private patients? For example, are detailed itemizations of ancillary charges audited on a sample basis to determine that departmental charges are correct? Similarly, if outpatient facilities are cost-reimbursed, are detailed itemizations of departmental charges audited?

8. Are other providers which bill on a cost basis (such as pharmacists in some states) audited on a sample basis to verify correct charges?

9. During field audits, are individual patient account balances reviewed for credit balances (may indicate duplicate payment or an insurance recovery by the institution)?

10. Are samples of admission and discharge documents taken to monitor possible billing errors in the computation of accommodation days?

11. Are medical certifications and recertifications for hospital stays audited on a sample basis?

12. Verify that the cost audit group or some audit group monitors all the potential erroneous claim situations where audit responsibility was noted on the worksheet listing potential erroneous payments (Appendix A). How extensive is the review for each?

13. Audit coverage

What providers are audited?

How often are providers audited?

If not periodic, how are audit targets selected?

What type of audit - desk, on site, etc.?

Person-days on typical audit?

QUESTIONNAIRE WORKSHEET

Post-Payment Edits

Some states use provider or recipient profiles as a means of detecting erroneous payments on a post-payment basis. For example, such edits may detect improper billing practices, such as billing more expensive procedures than appropriate (e.g. always billing initial office visits or extensive office visits). The purpose of this questionnaire is to determine the extent of such controls.

1. Are profiles used in detecting a continuous erroneous billing practice for a particular provider, e.g. the use of an inappropriate (more expensive) procedure code for a service?

2. Is a provider ever placed on prospective review? For an individual procedure or group of procedures? Is a procedure ever placed on prospective review for all providers? Is profile information used in determining that a provider should be placed on review?

3. Describe the post-payment edits across providers, e.g.

   (a) claim for assistant surgeon with no primary surgeon billed
   (b) claim for major surgery with no hospital claim
   (c) claim for drugs with no recent physician visit

4. Describe any other post-payment edits for erroneous payments.

QUESTIONNAIRE WORKSHEET

Information Feedback

In many instances, information is available in one area of Medicaid operations which would be valuable to some other functional group, but no established lines of communication for that information presently exist. The purpose of this questionnaire is to determine the extent of such communication or lack thereof.

1. When a claim indicates that a patient has died (e.g. through discharge reason), is that information used to update the eligibility records? Is it forwarded to the welfare office?

2. When an attorney requests listing of medical expenses for his client (either from a provider or from the Medicaid office), is that information referred to the third party liability recovery unit?

3. When a third party or insurance recovery is made on one claim, are related claims also investigated? Are there routine procedures for this?

4. If other insurance appears on a claim or a refund is received from a provider after collection from other insurance, and if other insurance is not indicated on the eligibility file, is this data captured and flagged for further investigation?

5. When it is observed that a particular provider has an improper billing practice for one or more procedures, is that provider placed on review so that all claims with those procedures are suspended? Is there an investigation of past claims for possible recovery? Are there routine procedures for this? Is there any feedback to the provider other than disallowing the particular claims?

6. If one service is disallowed, are related services investigated for the same episode of care by the same provider? By a different provider? For example, if a hospital stay is disallowed, are related hospital visits and ancillary charges also disallowed? Are there routine procedures for this?

7. If Medicare reduces, disallows, or corrects an error on a previously paid claim, is Medicaid informed? Has Medicaid requested such communication?

8. If a claim is reduced or denied, is the provider always made aware of the reason, either via the remittance document or an information copy of the adjusted invoice (prevents duplicate billings and promotes provider education)?

QUESTIONNAIRE WORKSHEET

Claim Format

During the course of the assessment, any aspects of the claim design which either facilitate or hinder proper controls should be noted. Examples of claim design aspects which aid in control are:

1. Indication of last refill or prescription of a drug.
2. Indication, on an inpatient claim, of whether the attending physician was private, unsalaried staff, or salaried staff.
3. Indication of the last time the recipient received a particular service (e.g. eyeglasses).
4. Indication on physician claim whether the case is related to surgery and, if so, the relevant details.

Examples of claim design aspects which hinder control are:

1. Ambiguous data definitions; e.g., "units" could mean RVS units or number of services; "amount charged" could be amount per service or total amount.
2. Lack of clear questions which require the provider to inquire about insurance or third party liability. For example "Does the recipient have insurance?" is preferable to "other payments" or "other sources of payment".
3. Lack of sufficient detail to determine what procedures have been performed, e.g. permitting providers to file Medicare crossover claims showing only the amount of coinsurance and deductible, not the services rendered.
4. Lack of written procedure description.
5. Lack of claim entries for various cross-checking totals; e.g., sum of individual charges compared to total charges, charges per unit and number of units compared to total charges for a service.

QUESTIONNAIRE WORKSHEET

Personnel and Training

When investigating various functional areas, the type of personnel employed (e.g., clerical, para-medical, and medical) should be documented. If clerical and para-medical personnel are found to be making judgmental evaluation of claims then it may be appropriate to note exemplary training practices found, along with comments when obvious lack of training programs hinders operational effectiveness.

1. Document training courses and requirements.

2. Document turnover of personnel.

3. Are there standard documents detailing manual processing procedures?

QUESTIONNAIRE WORKSHEET

File Maintenance

The emphasis in the following questions should be on the recipient eligibility file, the provider file, and the fee files. The intent of these questions is to determine whether there are any difficulties in maintaining accurate and timely files. In particular, the extent of control procedures, such as transaction verification, file sampling, and file reconciliation is examined.

1. Name the major reference files.

2. Estimate the normal time lag between the time when a recipient's status is determined to change (e.g. cancelled) and the time a corresponding transaction is implemented on the recipient eligibility file. Are there any circumstances which might increase this delay? Repeat this question for the provider eligibility file.

3. Are there sufficient safeguards to insure the integrity of reference files? Is access limited? Are keywords employed? Are audit trails generated?

4. Is past information ever destroyed during an update? e.g. old fee schedule, old eligibility period?

5. Are update transactions verified? How?

6. Is there a normal sampling of file information? How often? How extensive? Describe.

7. Is there a routine file reconciliation? How often? What error rates?

8. Is a complete hard copy of file made? How often? Is it used for detection of errors?

9. Is data ever purged from files? If so, is purged data kept on microfilm, hard-copy, or tape for future reference?

10. How many months' data are retained on the claims history file? Is additional history retained where needed to enforce regulations? Does the history file ever contain fewer months' history, e.g. immediately after a purge?

11. Does the history file contain denied, pended, and in-process claims in addition to paid claims? If not, are there other files containing these claims for the purpose of history edits?

QUESTIONNAIRE WORKSHEET

Quality Assurance Procedures

Quality assurance is the mechanism by which a state may help insure that its control system is operating as it is designed and intended to operate. Quality assurance procedures are thus key in detecting errors in manual processing, computer programming bugs, problems in accurate file maintenance, faulty or error-prone processing procedures, etc. The quality assurance procedures which are most commonly used include:

1. Sampling of paid claims to determine that all regulations have been satisfied, payments made correctly, and any recent system or regulation changes properly implemented.
2. Analysis of provider refunds or claim adjustments to determine the cause of erroneous expenditures which have been brought to the state's attention by providers.
3. Submittal of fictitious claims with the same purpose of #1.
4. Tabulation of claims rejected because of processing errors (e.g., key-entry), broken down by type of error and by personnel involved.
5. Sampling and reconciliation of reference files to insure accurate and timely maintenance.
6. Periodic review of manually-processed documents.

The purpose of this questionnaire is to determine the extent of such activities. (Note that questions relating to quality assurance of files are covered in the questionnaire on file maintenance.)

1. Describe briefly what quality assurance procedures exist for reviewing the claims processing operation? Who has responsibity? State agency? Fiscal intermediary? Are these standard procedures? How often? How extensive (numbers of claims, etc.)? Obtain results of Q.A. efforts.

2. Does quality assurance for paid claims include

   (a) research of samples of processed claims, regularly by the state or F.I.? by supervisors?

   (b) input of known erroneous claims?

   (c) special samples when regulations are changed?

   (d) review of adjustments, refunds, or voided checks, to determine the causes of erroneous payments brought to the state's attention by providers?

   (e) periodic review of manually processed documents?

   (f) review of rejected claims to determine whether many rejects are caused by system problems, transposition or key entry errors, manual processing errors, poor communication of billing procedures to providers, or computer edits which are not sufficiently refined to reject mainly those claims truly in error?

3. Describe the extent of key verification procedures, use of check digits, etc. in the entry of data.

4. Who has responsibility for reviewing reasonableness of statistical reports? Does this include reconciliation of different reports? Are there special procedures? Is this a casual or a formal responsibility?

5. Are there computer generated reports on errors? by manual processor?

6. Is it possible to trace every step of processing of every claim paid, denied, pended, or returned to the provider? Describe the audit trail. Is this capability available while the claim is still in the system?

QUESTIONNAIRE WORKSHEET

System Evaluation and Planning

An important aspect of the monitoring of a state's control system is the process by which decisions are made to modify the control system, i.e., to introduce new claim edits or to eliminate existing controls. Two key considerations in this process are the cost incurred by operating the particular edit (manual and/or computer) and the program dollar savings resulting from the control (including deterrence of erroneous claims). Hopefully, a quantitative comparison is made between these costs and benefits and the information is used in the decision-making process.

Even in those cases where a specific decision is not anticipated, there is a need for information indicating the extent of erroneous payments in areas which a state knowingly lacks controls. Such information provides a sound basis for planning and is crucial for monitoring any problem areas arising in the system operations.

In many states, there is a serious lack of an adequate level of program evaluation and planning for improvements. Management personnel are often aware of control deficiencies, yet have made no attempt to estimate the magnitude of erroneous payments resulting from such deficiencies. In some cases, conscious decisions have been made not to implement improved system controls or to relax existing controls and such decisions have been made without a quantitative consideration of the potential program dollars saved due to the controls.

1. How are changes in the controls on erroneous expenditures initiated? Are controls ever changed other than in response to changes in policy or regulation, e.g., to reduce the number of suspended claims, or to tighten controls?

2. Are studies ever performed to determine the cost-effectiveness of tightening or loosening controls on erroneous payments? Are samples taken to determine erroneous payments in areas which are not controlled? If so, obtain results.

3. Have conscious decisions been made to eliminate certain edits or not to implement edits, in any of the erroneous payment situations noted in Appendix A? In such cases, determine how these decisions have been made.

4. Are any incentives provided to the fiscal intermediary (if applicable) to improve the system (e.g. lower erroneous payments)? Is the fiscal intermediary paid on the basis of number of claims processed?

5. Who can authorize a change in the claims processing edits or procedures? What safeguards are there to prevent unauthorized changes? How is a program change documented? Who owns updated program?